Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

UVALDE MEMORIAL HOSPITAL
1025 GARNER FIELD RD
UVALDE TX 78801-4809

Respondent Name
TRANSCONTINENTAL INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-07-3569-01

MFDR Date Received
January 29, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Uvalde Memorial Hospital would like this claim reconsider has an emergency surgery inpatient stay. We spoke to Mary Ann at insurance and was told that no pre authorization was needed since this was an emergency surgery. . . . According to Texas Department of Insurance, Division of Workers' Compensation rule 134.401 acute care inpatient hospital fee guidelines, these rules shall not apply to acute care hospitals which are located in a population center of less than 50,000 persons and have 100 or less licensed beds. Uvalde Memorial Hospital is in a population center of less than 50,000 and we have less than 100 licensed beds. The inpatient guidelines do not apply."

Amount in Dispute: $11,591.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Provider is not entitled to reimbursement of its billed charges. It is entitled to reimbursement at a 'fair and reasonable' rate. . . . Provider has simply not met its burden of proof under rule 133.307(g)(3)(D) to establish that reimbursement of $11,591.85 meets the statutory standards under the Act for reimbursement of inpatient facility charges for the surgical procedure in question. On the contrary, this amount is grossly excessive… Therefore, Provider is not entitled to additional reimbursement."

Response Submitted by: Stone Loughlin & Swanson, LLP, One Northpoint Centre, 6836 Austin Center Blvd., Suite 280, Austin, Texas 78731

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 24, 2006 to May 26, 2006	Outpatient Hospital Services	$11,591.85	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. Former 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 *Texas Register* 6264, sets out the fee guidelines for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
4. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective review of health care.
5. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 45 – Charges exceed your contracted/legislated fee arrangement.
   - 900-021 – ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE NETWORK REFERENCED ABOVE.
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 855-002 – RECOMMENDED ALLOWANCE IS IN ACCORDANCE WITH WORKERS COMPENSATION MEDICAL FEE SCHEDULE GUIDELINES.
     - $0.00
     - $2,236.00
   - W3 – Additional payment made on appeal/reconsideration.
   - 920-010 – UPON RECEIPT OF A REQUESTED REPORT, THE RECOMMENDED ALLOWANCE HAS BEEN ADJUSTED.
   - W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
   - 850-054 – THE RECOMMENDED PAYMENTS ABOVE REFLECT A FAIR, REASONABLE AND CONSISTENT METHODOLOGY OR REIMBURSEMENT PURSUANT TO THE CRITERIA SET FORTH IN SECTION 413.011(D) OF THE TEXAS WORKERS' COMPENSATION ACT.
     - M – NO MAR $0.00
     - M – NO MAR $1,100.00
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.
   - 920-002 – IN RESPONSE TO A PROVIDER INQUIRY, WE HAVE RE-ANALYZED THIS BILL AND ARRIVED AT THE SAME RECOMMENDED ALLOWANCE.

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – "Charges exceed your contracted/legislated fee arrangement" and 900-021 – "ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE NETWORK REFERENCED ABOVE." Review of the submitted information found no documentation to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on May 31, 2012, the Division requested the respondent to provide a copy of the referenced contract(s) between Transcontinental Insurance Company and the alleged network, as well as a copy of the contract(s) between the network and the health care provider. Review of the submitted information finds no copy of a contract between the insurance carrier and the alleged network. No documentation was found to support that the insurance carrier had been granted access to the health care provider's contracted fee arrangement with the alleged network. The respondent has failed to establish that the disputed services are subject to a contractual agreement between the parties to this dispute. The Division concludes that these denial or reduction reasons are not supported. Consequently, these disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute involves inpatient hospital services rendered in an acute care hospital having100 or less licensed beds located in a population center of less than 50,000 persons. Accordingly, per former 28 Texas Administrative Code §134.401(a)(1), effective August 1, 1997, 22 *Texas Register* 6264, these services shall be reimbursed at a fair and reasonable rate.
3. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

5. Former 28 Texas Administrative Code §133.307(c)(2)(F)(ii), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement including "the requestor's reasoning for why the disputed fees should be paid or refunded." Review of the submitted documentation finds that the requestor has not explained the reasons that the disputed fees should be paid. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(ii).
6. Former 28 Texas Administrative Code §133.307(c)(2)(F)(iii), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issues including "how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues." Review of the submitted documentation finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iii).
7. Former 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issues including "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).
8. Former 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The Division has previously found, as stated in the adoption preamble to the former *Acute Care Inpatient Hospital Fee Guideline,* that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors" (22 *Texas Register* 6271). The Division further considered alternative methods of reimbursement that use hospital charges as their basis; such methods were rejected because they "allow the hospitals to affect their reimbursement by inflating their charges" (22 *Texas Register* 6268-6269). Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	August 9, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.